JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.
5010 York Road — Baltimore, MD 21212 — 410-433-2200 (toll free)1-888-JAI-1999 — fax: 410-433-4615

PROVIDER APPLICATION - Organization

As part of the application, please attach, for all physicians:
*** Curriculum Vitae or Resume**
*** Copies of all licenses and certifications, including Board Certification, if applicable**

I. GENERAL INFORMATION
(PLEASE TYPE OR PRINT)

Organization Name _____

Telephone Number _____ Fax Number _____

Billing Address: Provider Type _____

_____ Hours of Operation _____
Street

_____
City State Zip

II. PROFESSIONAL LICENSING, CERTIFICATION & OTHER IDENTIFIERS

License #		
State		
Type		
Effective Date		
Expiration Date		

NPI Number _____

Tax ID Number _____ **MA Provider Number** _____

III. LANGUAGE CAPABILITY

Do you have any staff that speaks a foreign language?

Language	**Level of Fluency**		
_____	Minimal	Moderate	Fluent
_____	Minimal	Moderate	Fluent
_____	Minimal	Moderate	Fluent

IV. ABOUT YOUR OFFICE

KEY ADMINISTRATIVE STAFF MEMBERS:

Office Manager name & telephone number:

_____

E-Mail Address: _____

Computer Software in use: _____

Network Capacity/Capability: _____

Capacity to Send Electronic Claims: ☐ Yes ☐ No

24 Hour Availability? ☐ Yes ☐ No

STAFF COMPOSITION:

Provide names and titles:

_____

_____

V. MEMBERSHIPS/PROFESSIONAL SOCIETY AFFILIATIONS

Name	Membership From/To		Offices Held

OTHER AREAS OF CERTIFICATION

Certification: _____

Issuing Entity _____

Certificate Number _____

Effective Date _____

Expiration Date _____

Certification: _____

Issuing Entity _____

Certificate Number _____

Effective Date _____

Expiration Date _____

VI. SPECIFIC MEDICAID DATA

Maryland Medicaid Experience? ☐ Yes ☐ No

With Whom? How Long? Average % of Total Pts.

_____

_____

_____

Current Medicaid Patient Population/Total Patient Population _____ %

Other Community Outreach Programs your organization offers:
(e.g. Community Health Education)

_____

_____

_____

Other special needs services your organization offers (Interpreter Services, TDD phones, etc.):

_____

_____

_____

VII. PLEASE RESPOND TO EACH OF THE FOLLOWING QUESTIONS. IF THE ANSWER TO ANY IS "YES," PLEASE EXPLAIN ON A SEPARATE SHEET.

A. Have any judgements or settlements been made against your organization in professional liability cases in the past five (5) years, or are any pending at this time?
☐ Yes ☐ No

B. Has your malpractice insurance ever been denied, canceled, non-renewed, or restricted?
☐ Yes ☐ No

C. Has your organization ever been, or are you currently being, accused of committing medical malpractice (regardless of whether a lawsuit was or has been filed against you)?
☐ Yes ☐ No (** If yes, you must request that a Malpractice Information Report be sent from your insurance carrier to JMSMCO.)

D. Has your organization's license to practice medicine ever been limited, suspended, or revoked in any jurisdiction?
☐ Yes ☐ No

E. Have any sanctions ever been imposed upon your organization by Medicare or Medicaid?
☐ Yes ☐ No

VIII. CERTIFICATION OF ACCURACY & RELEASE OF INFORMATION

I hereby certify that the statements included in this application are correct to the best of my knowledge. I hereby authorize and consent to the release of information to Jai Medical Systems Managed Care Organization, Inc. (JMSMCO) on request regarding any information concerning this organization as long as such releases of information are provided in good faith and without malice. I hereby release from all liability JMSMCO, its staff, and employees for use of or reliance upon such information. I understand and agree that this organization, as a potential participating provider, has the burden of producing adequate information for the proper evaluation of its professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

_____ _____

Signature of Representative Date

_____

Printed Name of Representative
(Organization Name)